Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *(Analysis and Aggregation)*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	SP-1: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members. The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	The MCO ensures that the Case Manager, Community-based Case Manager or Integrated Health Home Care Coordinator has addressed the member's health and safety needs in the member's service or treatment plan. The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members. The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Continuously and Ongoing

		for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.				
	SP-2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
	SP-3 The IME will measure the number and percent of service plans which were revised when warranted by a change in the	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans	See SP-1 Above				
	SP-4: The IME will measure the # and percent of members' service plans that identify all the following elements; amount, duration, and funding sources of all services and all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
	SP-5: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	Numerator = # of IPES respondents who stated that they were a part of planning their services; Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.					
	SP-6: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers. Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed..	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

Providers meet required qualifications.	QP-1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity.	Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME Provider services.	Contracted Entity (Including MCOs)	Data is Collected Monthly	Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider	Data is Aggregated and Analyzed Quarterly

	Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.	The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services. The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if			requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider makes these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO. If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.	

		noncompliance persists. .Data is inductively analyzed at a 100% level.				
	QP-2: The IME will measure the total number and percent of providers, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review .	OnBase and MCO reports are used to retrieve data associated with the number reviewed providers who meet training requirements. Data is inductively analyzed of 100% sample spread over 5 years. The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services. The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	See QP-1 Above	Data is Aggregated and Analyzed Quarterly

		records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.				
Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements Denominator: The total number of service plans reviewed.	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The IME Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The IME Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	Data is Aggregated and Analyzed Quarterly

	SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements. Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements Denominator: The total number of service plans reviewed.	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The IME Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The IME Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	Data is Aggregated and Analyzed Quarterly
The SMA retains authority and responsibility for program operations and oversight.	AA-1: The IME shall measure the number and percent of required MCO HCBS Performance Measure Quarterly reports that are submitted timely. Numerator: # of MCO HCBS Performance Measure Quarterly Reports submitted timely Denominator: # of MCO HCBS Performance Measure Quarterly reports due in a calendar quarter.	Contracted Entity and MCO performance monitoring. Data is inductively analyzed at a 100% level. Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are	State Medicaid Agency and Contracted Entity (Including MCOs	Data is reported Monthly	Each MCO contract manager is responsible for ensuring that the MCO submits reports timely. If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation. General methods for problem correction include revisions to state contract terms based on lessons learned.	Data is Aggregated and Analyzed Quarterly

		immediately addressed by each MCO account manager to the respective MCO.				
	AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter	Contracted Entity performance monitoring. Data is inductively analyzed at a 100% level. See AA-1 Above	State Medicaid Agency and Contracted Entity (Including MCOs	Data is Collected Monthly	See AA-1 Above	Data is Aggregated and Analyzed Quarterly

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	FA-1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims	The Program Integrity (PI) unit requests service documentation from providers and cross-walks with claims. The Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. Per the contract with IME, the PI unit is required to review 0.5% of MMIS paid claims. PI will review 100% of the claims based on their request for claims that meet certain criteria.	Contracted Entity (Including MCOs)	Data is Collected Quarterly	When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension. The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis. If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.	Data is Aggregated and Analyzed Quarterly
	FA-2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator = # of Managed Care provider	MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care. Data sources includes; Claims Data, adjudicated claims summary, claims aging summary, and claims lag report	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	claims.					
	FA-3: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.	See FA-2	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-2 Above	Data is Aggregated and Analyzed Quarterly
	FA-4: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.	See FA-2	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-2	Contracted Entity (Including MCOs)

The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	HW-1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated. Numerator = # of critical incidents that received follow-up as required; Denominator = # of critical incidents requiring follow-up escalation	The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.	Contracted Entity (Including MCOs)	Data is Collected Monthly,	The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If a these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports. The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.	Data is Aggregated and Analyzed Monthly, Quarterly and Annually
		The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver				

		members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.				

	HW-2 The IME will measure Critical Incident Reports (CRIS) that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIRs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death	See HW-1 Above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Monthly, Quarterly and Annually
	HW-3: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days; Denominator = # of critical incidents that	See HW-1 above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Monthly, Quarterly and Annually

	resulted in a targeted review					
	HW-4: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed that identified having policies for restrictive measures.	Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed ve.	Contracted Entity (Including MCOs)	Data is Collected Monthly	The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review.. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly
	HW-5 The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan; Denominator = # of provider Quality	Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed	Contracted Entity (Including MCOs)	Data is Collected Monthly	The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review.. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly

	Assurance Reviews completed..					
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	LC-1: IME will measure the number and percent of needs based eligibility decisions. Numerator: # of completed needs based eligibility reviews Denominator: # of referrals for needs based eligibility review	The data informing this performance measure is pulled from ISIS Reports are pulled and data is inductively analyzed at a 100% level.	State Medicaid Agency & Contracted Entity	Data is collected monthly	The state's Medical Services Unit performs internal quality reviews of initial and annual 1915(i) eligibility determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the care coordinator or community based case manager take steps to initiate a new 1915(i) eligibility determination through communication with the member and physician. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly

The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	LC-2: The IME shall determine the number and percent of initial needs based eligibility decisions that were accurately determined by applying the approved needs based eligibility criterion using standard operating procedures. Numerator: # of needs based eligibility decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of	The Medical Services Unit performs internal quality reviews on a representative sample of the 1915(i) eligibility determinations that have been made with a 95% confidence level. Data is reported on a quarterly basis and inductively analyzed. Data for completed needs based eligibility determinations is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems	State Medicaid Agency & Contracted Entity	Data is collected Monthly	. The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff	Data is Aggregated and Analyzed Quarterly

	reviewed needs based eligibility determinations.	perspective to determine in procedural standards. Monthly a random sample of needs based eligibility decisions are selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated needs based eligibility criteria				

System Improvement:
(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
State QA/QI system, at a minimum, addresses the following items: (1) health and safety issues of members receiving HCBS services; (2) abuse/neglect/ exploitation of members; (3) member access to services; (4) plan of care discrepancies; (5) availability of services; (6) complaints of service delivery; (7) training of providers, case managers, and other stakeholders; (8) emergency procedures; (9) provider qualifications; and (10) member choice. Based on contract oversight and performance measure implementation, the	The IME is the single state agency that retains administrative authority of Iowa's HCBS services. Iowa remains highly committed to continually improve the quality of services for all HCBS programs. The QIS developed by Iowa stratifies all HCBS services, including the State's 1915(c) waivers and 1915(i) state plan services. Data is derived from a variety of sources including the MCOs, HCBS Provider Quality Oversight databases, site reviews, follow-up compliance reviews, compliant investigations, evaluation reports, member satisfaction surveys, member interviews, and member records.	Data is Collected Continuously and Ongoing	The IME reviews the State QIS system no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often than annually due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.			The IME employs a Quality Assurance Manager to oversee data compilation and remediation activities. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/ Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.			Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. Data from QA/QI activities is also presented to the HCBS QA/AI Committee on a quarterly basis. The QA/QI Committee reviews the data makes recommendations for changes in policy to the IME Policy staff and Bureau Chief. The Committee also uses this information to direct HCBS Provider Quality Oversight Specialists to provide training, technical assistance, or other activity. The Committee monitors training and technical assistance activities to assure consistent implementation statewide. The Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage. The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement. A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.			The Committee is made up of certain HCBS Provider Quality Oversight staff and supervisors, and IME Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvements are made. Finally, IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa Association of Community Care Providers. Reports are also available to agencies, waiver providers, participants, families, and other interested parties upon request.

In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries.	MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. IME performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan. In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.
All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas.	MCO QM/QI programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state an authenticated as it can be used during onsite visits and through regular reports.

	outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QA/QI plan.		
MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC.	If not already accredited, the MCO must demonstrate it has initiated the accreditation process as of the MCO's contract effective date. The MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State. When accreditation standards conflict with the standards set forth in the MCO's contract, the contract prevails unless the accreditation standard is more stringent. MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed.	Reviews are Conducted Every Three Years	NCQA and URAC publically report summarized plan performance, as well as accreditation type, accreditation expiration date, date of next review and accreditation status for all NCQA accredited plans in a report card available on the NCQA website. This report card provides a summary of overall plan performance on a number of standards and measures through an accreditation start rating comprised of five categories (access and service, qualified providers, staying health, getting better, living with illness).

STATE PLAN UNDER TITLE XIX 0F THE SOCIAL SECURITY ACT

State/Territory: IOWA

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

The following methods help assure quality of care and services under the Medical Assistance program.

1. A Medical Assistance Advisory Council assists the Department in planning the scope and content of medical services provided under the program.

2. The services of professional technical advisory committees are used for consultation on all services provided under the program.

3. Procedures exist to assure that workers in local Human Services offices are able to assist people in securing necessary medical services.

4. Procedures are in effect to pay for necessary transportation of recipients to and from providers of medical and health services.

5. The State has in effect a contract with the Iowa State Department of Inspections and Appeals to survey intermediate care facilities, intermediate care facilities for persons with intellectual disabilities and skilled nursing facilities and to certify whether they meet the conditions to participate as providers of service under the Medical Assistance program.

6. The Department has in effect a Utilization Review Plan for evaluation and surveillance of the quality and quantity of all medical and health services provided under the program.

7. Physician certification, recertification and quality of care issues for the long term care population are the responsibility of the Iowa Medicaid Enterprise's Medical Services Unit, which is the Professional Standards Review Organization in Iowa.